Rhode Island Health Care Quality
Performance Measurement and Reporting

AN ENVIRONMENTAL SCAN
OF THE
THE FUTURE DEVELOPMENT OF QUALITY MEASURES
AND
EXTERNAL FUNDING SUPPORT
FOR
PUBLIC REPORTING INITIATIVES

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Patricia A. Nolan M.D., MPH
Director

Donald L. Carcieri
Governor

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Prepared for Rhode Island Department of Health:

By:
Marcia K. Petrillo, MA
Chief Executive Officer, Qualidigm
100 Roscommon Drive
Middletown, Ct 06457
Executive Director, Quality Partners Of Rhode Island

Joshua Fenton
President and Chief Executive Officer
The Fenton Group

INTRODUCTION:

Since the passage of the state legislation (Chapter 17-17 of the General Laws of Rhode Island: "An Act Relating to Health and Safety-Establishing the Rhode Island Health Quality Performance Measurement and Reporting Program.") in 1998, public reports of hospital-specific quality of clinical care and patient satisfaction, nursing home-specific clinical quality of care, and statewide measures of hospital care based on administrative data have been released to the public. With the continuation of funding in the FY04 state budget, the second hospital-specific patient satisfaction report was published in Fall 2003, and work is beginning on the design of the first nursing home resident satisfaction report.

At this time in the implementation of the state public reporting program, it is essential for planning purposes to determine the future direction of quality measures development and report design. In the current budget environment, it is also important to identify potential sources of funding for ongoing development and updating of the hospital and nursing home reporting programs, while initiating a program in the home health setting. The environmental scan reported herein was commissioned by the Rhode Island Department of Health (HEALTH) to address these two topics. The first section of the scan relates to the development of new measures and report design that may be suitable for public reporting. The second section reports on potential funding sources to support these efforts, including the evaluation of the impact of such reports on consumer knowledge and provider quality of care.

Section 1: Future Development of Clinical Quality and Patient Satisfaction Measures and Public Reporting Design

In researching which groups are developing measures and reports that may be suitable for public reporting, it is clear that the federal government, accreditation groups, non-profit entities related to quality improvement, and employer created or supported private sector groups are leaders in these efforts. This section presents a review of the primary initiatives identified during the scan process. Appendix A offers the website addresses for those programs/organizations discussed in detail in this report.

FEDERAL GOVERNMENT INITIATIVES:

The two key agencies (the Centers for Medicare and Medicaid Services, and the Agency for Healthcare Research and Quality) supporting public reporting measures development and report design are profiled below. Both of these agencies are located within the U.S. Department of Health and Human Services (DHHS). Increasing consumer and patient use of health care quality information is Goal Number 5 in DHHS's Strategic Plan for FY 2003 – 2008. Other federal government agencies, such as the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA) do not support measures development and report design directly. However, they provide data that may influence future topic selection and clinical background for measures.

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS), is committed to the public reporting of comparative quality information at the provider level to drive quality improvement and inform consumer choice. Even before DHHS had a formal goal related to making this type of information available to the public, CMS had initiated the development of quality indicators (later identified as measures) for Acute Myocardial Infarction, Heart Failure, and Pneumonia. Beginning in 1996, these indicators were used

to measure the quality of care provided to Medicare beneficiaries in hospitals on an aggregate statewide and national basis. Measurement of this level of hospital performance was incorporated as a formal component of CMS's Quality Improvement Organization (QIO) program in 1996.

CMS currently reports other comparative quality information related to managed care plans (both plan–specific quality of care and patient satisfaction), dialysis facilities (facility-specific quality of care), nursing homes (facility-specific quality of care), and home health agency-specific quality of care. CMS is able to report on these settings because the plans and the facilities/agencies are required to submit routinely to CMS patient level data. These data serve as the basis of these comparative reports. No such requirement for data submission exists in the hospital setting; however, the Medicare Modernization Act of 2003 includes a financial incentive to hospitals to report these data.

In concert with the Agency for Healthcare Research and Quality (AHRQ), CMS has awarded a contract to the National Quality Forum (NQF) to identify core sets of measures for public reporting in the hospital, nursing home and home health settings. This effort is discussed in greater detail on page 7. The NQF is also charged with outlining a national public reporting strategy that can provide guidance to public reporting initiatives.

At approximately the same time that CMS contracted with the NQF, CMS collaborated with HEALTH, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Hospital Association of Rhode Island (HARI), and Qualidigm (the Connecticut QIO), to develop a core set of hospital performance measures. This project was one of the first steps in the eventual alignment of AMI, HF and pneumonia measures originally developed separately by CMS and JCAHO. This alignment was completed in 2003, one year after the completion of the Rhode Island project.

This project also resulted in the development of the "opportunity model" for reporting of quality measures, i.e., how many opportunities does the hospital have to provide the "right" service to a patient, and how many times does the hospital provide that service.

The model, which creates a composite score across selected measures related to a specific condition, accommodates for the small sample size of patients in a high proportion of hospitals with fewer than 200 beds.

Measures related to conditions other than AMI, HF, and pneumonia will be developed by CMS over time. The first potential new set focuses on the prevention of surgical infections. Development of a measures set for depression is also under consideration.

CMS is also testing a hospital pay for performance program with a select group of Premier, Inc. affiliated hospitals. The program is based on thirty-five clinical measures related to CABG (Coronary Artery Bypass Graft), Hip/knee replacements, AMI, HF and CAP (Community Acquired Pneumonia). Hospitals will be rewarded financially for achieving specific levels of quality care performance.

CMS is investigating the possibility of using Medicare claims and administrative data to produce measures for public reporting on structure (e.g. volume), process, and outcome (e.g., readmission and mortality for AMI). No decisions, however, have been made to do so at this time.

CMS is collaborating with AHRQ to develop a standardized patient experience (satisfaction) instrument that can be utilized in the hospital setting. The measures in this instrument may be incorporated into the existing satisfaction instruments already offered by private sector survey vendors. The testing of the instrument is being undertaken by three QIOs (Arizona, Maryland and New York) under a CMS pilot project. The same instrument is being tested in Connecticut through a separate federal/state collaborative and the state's QIO, Qualidigm.

The three-state CMS pilot and the CMS/Connecticut collaborative projects are testing the measures for the new national voluntary effort for hospital clinical quality reporting. These measures are almost identical to those already being reported by Rhode Island's program discussed in detail on page 10. This same set of clinical measures has become

the inaugural measures set for a national voluntary hospital reporting program described on page 12.

Agency for Health Care Research and Quality (AHRQ)

The mission of the Agency for Health Care Research and Quality (AHRQ) of the U. S. Department of Health and Human Services is to support, conduct and disseminate research that improves access to care and the outcomes, quality, cost and utilization of health care services. One of its strategic goals is to strengthen quality measurement and improvement.

The research sponsored and conducted by AHRQ makes available information to the public that enables better decisions about health care. The Agency has been developing and/or disseminating guidelines for care related to a variety of clinical conditions for many years. These guidelines are being used by health care providers: hospitals, nursing homes, home health agencies, physician offices, etc., to support the management of care of their patients. They are not, however, considered measures that are necessarily appropriate for public reporting purposes. AHRQ maintains a website that includes a library of these guidelines/measures (http://www.qualitymeasures.ahrq.gov).

AHRQ also routinely collects data from a variety of health care settings to develop databases available to the public to support research, comparative public reporting, and other purposes. These databases are derived from administrative data and do not identify individual providers. Data from AHRQ's Healthcare Cost and Utilization Project (HCUP), were used as the comparative source for the Rhode Island report on "A Review of the Current State of Public Reporting on Health Care Quality Performance: States, Hospitals and Coalitions" published by HEALTH in July 2000; "Trends in Quality Indicators for Health Care in Rhode Island (1994-1998); and Hospital Care, Access to Care and Utilization of Inpatient Procedures" in August 2001.

AHRQ has also developed the CAHPS instrument, the Consumer Assessment of Health Plans survey tool, to measure member satisfaction with their plans. Since 1997, this instrument has undergone a series of refinements and is widely used in both the public and private sectors (most notably, the National Committee for Quality Assurance, NCQA, as one segment of its annual Health Plan Report Card).

Most recently, AHRQ was asked by CMS to develop an instrument to survey patient experience (satisfaction) in the hospital setting. The instrument is being tested in the three state QIO pilot project and the CMS/Connecticut collaborative project mentioned earlier. It should be available for general use sometime in 2004. Shoshanna Sofaer, DrPH, who consulted with HEALTH in the development of the Rhode Island patient satisfaction report, is a member of the AHRQ team developing the instrument.

AHRQ has also funded research to develop survey instruments to assess resident and family satisfaction in the nursing home setting. This project will not be completed for several years.

And finally, at the request of CMS, AHRQ is developing a set of measures for the reporting of clinical quality in the home health setting. This set will be submitted to the National Quality Forum for consideration and endorsement sometime in 2004.

STATE GOVERNMENT INITIATIVES:

A number of states have begun issuing reports on quality of care in the last decade. The most well known of the early reporting programs are the reports on hospital quality issued by Pennsylvania, and the New York report on the quality of cardiac surgery.

Rhode Island was the first state to pass comprehensive legislation requiring public reporting and quality improvement across multiple settings of care. The state of Maryland initiated public reporting on multiple settings of care in 2002. It chose to publish a nursing home clinical report first, followed by a report on hospital clinical care.

Several other states are now publishing quality reports or developing reporting programs. The data sources used for these reports are mainly administrative in nature.

PRIVATE SECTOR INITIATIVES:

There are numerous private sector initiatives in measure development and public reporting under way at this time. Highlighted in this report are the groups and their initiatives which are most closely aligned with the Rhode Island program.

The National Quality Forum (NQF)

A shared sense of urgency about the impact of health care quality on patient outcomes, workforce productivity, and health care costs prompted leaders in the public and private sectors to establish the NQF in 1999 as a mechanism to bring about national change. Its creation was proposed in the report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry published in 1998.

Established as a not-for-profit public-private partnership, the NQF has broad participation from all parts of the health care system, including national, state, regional and local groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries, and organizations involved in health care research and improvement. The members of the NQF work together to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement.

The NQF is very active in the arena of public reporting. As its first task, the NQF convened a panel of leading experts in quality improvement and measurement to identify the principles and priorities that should guide a national measurement and reporting strategy. Building on this effort and the work of public and private quality improvement organizations, the NQF endorses quality measures for national use. Its typical approach

is to convene an expert panel related to each topic being considered for reporting. The panel reviews all measures available for consideration and identifies a draft set of measures most suitable for public reporting. This set is then sent out for review by all members of the NQF before a set of measures is formally endorsed by the organization.

Under contract with CMS, the NQF has undertaken efforts to identify and endorse clinical quality measures in the nursing home and hospital settings. A similar effort to endorse a set of clinical measures in the home health setting began in Fall 2003. A set of measures relating to diabetes care is also under review at this time.

The National Committee for Quality Assurance (NCQA)

NCQA is a private, not-for-profit organization dedicated to improving health care quality. It was established in 1990 by the employer community to support cost-effective quality care, with a focus on the quality of the nation's managed care plans.

NCQA's most widely recognized public report is the Health Plan Report Card. It is published annually on all health plans accredited by NCQA. The plan-specific report includes information on the quality of care received by, and member satisfaction with, the plan's services. It is derived from administrative data, record abstraction, and a written member satisfaction survey. The data are reported at the plan level. No individual provider level data are available. HEALTH utilizes information from the card to report on the performance of Rhode Island health plans.

NCQA uses an approach similar to CMS, AHRQ, and JCAHO in developing the measures for its report card. This includes a literature search and convening of an expert panel to select the measures, consider comments from its members and other interested parties, followed by field testing. The results of the search, the comment review, and the field test are analyzed by the panel and a final selection of measures is determined. A review of its existing measures, and development of new ones, is conducted annually.

In addition to developing measures for its own use, NCQA also works under contract with other groups to support their measures development. For example, CMS contracted with NCQA to assist in the development of their Medicare and Medicaid managed care plan quality measurement programs.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

JCAHO is an independent not-for-profit organization that evaluates and accredits over 16,000 health care organizations including, but not limited to, hospitals, nursing homes, and home health care agencies. Accreditation is based on JCAHO developed standards and performance measurement requirements. The state of Rhode Island requires hospitals to hold JCAHO accreditation as a prerequisite for state licensure.

In 1997, JCAHO introduced its ORYX initiative which integrates performance measurement data into the accreditation process. Refinement of the initiative as it applies to hospital performance was begun several years later. This refinement resulted in the development of a set of core performance measures related to AMI, HF, pneumonia and, pregnancy and related conditions. The measures for AMI, HF and pneumonia were pilot-tested in Rhode Island as part of the CMS, JCAHO, HEALTH, HARI, Qualidigm project (described on page 4). The resulting data were used to populate the state's first and second clinical quality reports on hospitals issued in 2002 and 2003. JCAHO is continuing to develop additional measures sets that may be applicable to the state's reporting program in the future.

The Foundation for Accountability (FACCT)

FACCT was established as a not-for-profit foundation in 1995. It was created as a result of several meetings of the Jackson Hole Group whose participants agreed to form an organization to improve health care by advocating for an accountable and accessible system where consumers are partners in their care and help shape delivery of that care.

FACCT's approach is to communicate directly with consumers in helping them to understand key facts about health care quality, to demand quality information, and to use it to make informed choices. It has a web-based clearinghouse for consumer centered health care materials, resources and information, as well as such tools as *Compare Your Care* that offers access to health care information and support.

The Leapfrog Group

The Leapfrog Group for Patient Safety: Rewarding Higher Standards initiative was established by the Business Roundtable in 2000. It is supported by the Robert Wood Johnson Foundation, Leapfrog members (over 140 public and private organizations) and others.

The Leapfrog mission is to trigger a giant leap forward in quality, customer service and affordability of health care of all types by:

- Making the American public aware of a small number of highly compelling and easily understood advances in patient safety, and
- Specifying a simple set of purchasing principles designed to promote these safety advances, as well as overall customer value.

Leapfrog developed its initial measures set related to the hospital setting. The measures focus on improving patient safety through Computer Physician Order Entry; Evidence-Based Hospital Referral for selected complex medical procedures; and ICU physician staffing. The collection of data related to these measures began in 2001 and is now being provided by 557 hospitals in 22 regions of the country. Hospitals participate on a voluntary basis and are rewarded for participation and performance.

National Voluntary Hospital Reporting Program

In December of 2002, a group of national organizations (the American Hospital Association, the Association of American Medical Colleges, and the Federation of

American Hospitals) endorsed/supported by CMS and JCAHO announced the introduction of a program (National Voluntary Hospital Reporting Initiative) to report to the public about the quality of care provided in hospitals. Reporting by hospitals is voluntary and based on ten measures selected from the core measures sets for AMI, HF, and pneumonia (derived from the JCAHO/CMS aligned measures). A voluntary reporting program of this potential size is unprecedented and could eventually include data for approximately 5,000 hospitals. Hospitals that treat Medicare beneficiaries are incentivized to participate in the program by a provision included in the Medicare Modernization Act passed by the Congress in 2003.

The first voluntary report of hospital quality, hosted on the CMS website, was published in Fall 2003. Data for all acute care general hospitals in Rhode Island will be included in the Winter 2004 edition. The report features clinical measures (AMI, HF and pneumonia), and may be expanded to include a hospital-specific patient experience component in the future. Additional clinical measures will be included over the next several years.

OTHER INITIATIVES:

Many purchasers have undertaken public reporting initiatives in the past five years -- the Pacific Business Group on Health, Ford Motor Co., the United Auto Workers group, the Employer Health Care Alliance in Wisconsin. Most of these reports are based on administrative measures and/or patient satisfaction. The goals of the reports are to inform consumer choice and motivate quality improvement.

The most recent development in performance measurement is a category of initiatives labeled “pay for performance”. There are approximately twenty of them across the United States. They are led by employers, business coalitions, managed care organizations, payers and purchasers. A table identifying them is included as Appendix B. CMS is also engaged in a pay for performance pilot with a select group of Premier, Inc. hospitals as described on page 5.

Nearly all of the purchaser initiatives rely only on administrative data for measuring quality. Some of them use NCQA measures, some use pharmacy data, and others use predictive modeling. The majority of them reward performance at the plan or physician level. There are several, however, that recognize hospital performance. Two of these are the Pacificare Health Systems and Leapfrog.

Most of the programs rely on a composite score of a variety of measures (safety, condition-specific, outcomes, competencies, pharmacy, service, etc.) that may or may not be appropriate for public reporting. An in-depth review of the measures may yield some that have been tested and may be appropriate for public reporting.

SUMMARY:

There are four major conclusions that can be drawn from this measures environmental scan. They are key to the ongoing maintenance and development of the Rhode Island public reporting program.

Conclusion One

The Rhode Island program is moving in concert with the direction of other major public and private sector initiatives in public reporting. It can be considered a reflection of the state of the art in these types of initiatives.

Conclusion Two

The one area where there is no activity in the development of measures and report design is patient satisfaction in the home health setting. This may be a strategic opportunity for development funding for a pilot in Rhode Island.

Conclusion Three

Each of the organizations described in this section of the report represents opportunities for HEALTH to explore in an effort to continuously improve its reporting program. These organizations can be viewed from several perspectives:

- As resources for off-the-shelf new measures and report design;
- As partners to develop and test new measures/report design;
- As funding partners to develop and test new measures/report design; and
- As partners to seek funding from other sources for development and testing of new measures/report design.

Conclusion Four

To assure that Rhode Island is prepared to seize these opportunities, it is suggested that HEALTH:

- Establish ongoing one-on-one dialogue with each of the organizations;
- Follow the activities of each group via membership in the organizations (if possible), meeting attendance, and review of its written and web-based materials; and
- Disseminate copies of each report issued by HEALTH to these organizations to keep them apprised of program progress and direction.

Section 2: Potential Funding Sources to Support Measures Development and Report Design

There are both public and private sources that have the potential to support initiatives related to the Rhode Island public reporting program. That being identified, the public sources (federal government agencies) are experiencing constraints on available dollars to fund such initiatives. The private sources, mainly foundations, are experiencing similar constraints due to the downturn in the economy which impacts their return on investment on funds that support their pools of grant making dollars.

In conducting this search of funding sources, all government agencies with any relation to the topic of healthcare quality were reviewed. Those which were identified as potential sources are described below. A similar search of private funding sources (foundations) was conducted to identify those that may have an interest in the reporting program. The relevant key public and private sources are discussed in this section.

PUBLIC (FEDERAL GOVERNMENT) FUNDING RESOURCES:

Health Resources and Services Administration (HRSA)

HRSA is located within the U.S. Department of Health and Human Services. It is known as the "Access Agency" reflecting its purpose to assure the availability of quality health care to low income, uninsured, isolated, vulnerable and special needs populations. Rhode Island is eligible for funding under several of HRSA's grant programs that target rural health quality improvement. These are described below.

HRSA's State Rural Flexibility Program supports work with rural communities and hospitals to develop and implement a rural health plan, designate critical access hospitals (CAHs), develop integrated networks of care, improve emergency medical services and improve quality, service and organizational performance. The grant funding range is $200,000-700,000.

HRSA's Health Professional Workforce Analysis Program provides funding for the development of information describing the health professions workforce and the analysis of workforce-related issues, and to provide necessary information for decision-making regarding future directions in health professions and nursing programs. To be eligible for funds, grant applications must be submitted in conjunction with a hospital. The grant funding range is $50,000-400,000.

HRSA's Rural Health Outreach and Rural Development Program makes funds available to expand access to, coordinate, restrain the cost of, and improve the quality of essential health services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions. The grant funding range is $50,000-200,000.

HRSA's Rural Health Outreach and Rural Development Program offers development planning grants, outreach grants and network development grants. The grant funding range is $50,000-200,000.

The Agency for Healthcare Research and Quality (AHRQ)

AHRQ is located within the U.S. Department of Health and Human Services.
As described in Section 1 (pages 6-7), AHRQ's mission is to support, conduct and disseminate research that improves access to care and the outcomes, quality, cost and utilization of health care services. One of its strategic goals is to strengthen quality measurement and improvement. This includes measures development, contributions to the science of quality, and evaluation of the impact of public reporting.

The Agency's mission and strategic goals align well with the purpose of the Rhode Island program. It should be noted, however, that the competition for awards is intense and an award to a first time applicant is not the norm. The grant review and award process can

take six to nine months and the actual dollar flow may not begin until several months after award.

Since AHRQ is a research agency, the grant proposal needs to be framed within the context of a research question/hypothesis. To best position a proposal for approval, the applicant should be affiliated with a researcher from a university (e.g., Brown, University of Rhode Island) or a research organization (e.g., RAND). The dollar value of the award can range from $50,000-5,000,000+.

The Centers for Medicare & Medicaid Services (CMS)

CMS is located within the U. S. Department of Health and Human Services.
As discussed in Section 1 (pages 2-5), CMS is committed to the public reporting of comparative quality information at the provider level to drive quality improvement and inform consumer choice. This is a commitment which began almost ten years ago when its Peer Review Organization (PRO) program (now the Quality Improvement Organization (QIO) program) initiated special projects to develop quality measures. The Rhode Island program benefited from this commitment through a special project awarded to Qualidigm in 2000. The work performed under this project supported, in part, the development of the Rhode Island program's 2002 hospital report on clinical quality.

There are several options available to obtain CMS funding. The primary source for public reporting support is through the Quality Measurement and Healthcare Assessment Group. The majority of awards are made through the QIO Program. Concepts for projects may be submitted by a QIO at any time. From time to time, CMS will also issue requests for proposals from QIOs on topics of interest to them.

The second CMS source for funding support is through the Office of Research and Demonstration, although public reporting as a topic is not its primary focus at this time. Concepts for projects may be submitted at any time.

PRIVATE FUNDING RESOURCES:

Following a review and analysis of over 5,000 foundations to determine their relevance to public reporting, four key foundations were identified. In 2002, these foundations awarded over 8,700 grants. Only seventeen of those were related to quality improvement/public reporting initiatives. **(table of the 17 to be inserted)**

There is a growing interest among these foundations to partner with each other and other entities such as CMS to fund the development of programs to reward physicians and hospitals for the delivery of quality care. The largest program award to date ($4.9 million awarded to six projects) is sponsored by the combined resources of the Robert Wood Johnson (RWJ) Foundation, the California HealthCare Foundation, and the Commonwealth Fund. The program is called Rewarding Results and was established to implement the Institute of Medicine's recommendation to reward quality care. In conjunction with this program, AHRQ has awarded a grant to Boston University to conduct a comprehensive national evaluation of the six projects.

The foundations that are most closely aligned with the purpose of the Rhode Island public reporting program are described below. There are five of them and they all have a national geographic focus.

The Commonwealth Fund

The program areas of this foundation include: improving insurance coverage and access to care; and improving the quality of health care services. The Commonwealth Fund is one of the partner foundations that are supporting the Rewarding Results program described above.
The Commonwealth Fund's grant awards range from $10,000 to $8.5 million.

The Robert Wood Johnson Foundation

The program areas of this foundation include: assuring that all Americans have access to quality health care at reasonable cost; improving the quality of care and support for people with chronic health conditions; and promoting healthy communities and lifestyles. RWJ is the primary funder of the Rewarding Results program described above. The RWJ grant awards range from under $100,000 to $30,000,000.

In a grant award unrelated to the Rewarding Results program, HEALTH, with Quality Partners of Rhode Island (QPRI) as a partner, is the recipient of an RWJ grant to improve the quality of diabetes management services provided in the outpatient setting. There are ten physician offices/groups that are collaborating with HEALTH and QPRI to improve their office systems in the yearlong project.

The W.K. Kellogg Foundation

The purpose of the W.K. Kellogg Foundation is to improve the health of people by improving health services through system integration of community-based public health, prevention and primary care services. The W.K. Kellogg Foundation has five strategies to accomplish this: inform policy makers of needed changes in policy and practice; encourage developing models of comprehensive health care based on reorienting services toward public health, primary care and prevention; expand the health work force so that it is more reflective of the racial, ethnic, cultural and geographic makeup of the populations served; increase access, especially for vulnerable populations; and build the capacity of communities to form active partnership with institutions. Their grants range from $10,000 to $8.4 million.

The J.A. Hartford Foundation

The primary purpose of the foundation is to address the unique health needs of the elderly. This is accomplished through funding of initiatives related to long-term care;

medication in chronic health problems; increasing the nation's geriatric research and training capability; and improving integration of financing and care delivery for comprehensive geriatric services. J.A. Hartford Foundation grants range from $10,000 to $8.5 million.

The Virginia G. Piper Charitable Trust

The purpose of the Virginia G. Piper Charitable Trust is to help seniors gain access to services critical to their well-being and quality of life. This purpose applies to: improving the quality of and access to services for the elderly; providing assistance that enables seniors to remain independent; and keeping seniors engaged in their community. The Virginia G. Piper Charitable Trust awards range between $10,000 and $2,000,000.

The Rhode Island Foundation

In addition to the national foundations discussed above, there are local foundations that may present opportunities for financial support for the Rhode Island program. One of these is the Rhode Island Foundation. The Rhode Island Foundation's Strategy Grants Program may align best with the public reporting program. These grants are awarded to projects that promise significant improvements in: policy, advocacy and systems reform; organizational and leadership development; and innovative models and proven programs. The Rhode Island Foundation awards grants in the range of $5,000 to $4 million.

SUMMARY:

In summary, there are opportunities to seek external funding to support aspects of the Rhode Island reporting program. These opportunities, however, are limited in number and highly competitive. To position the program best for an award, the proposed initiative needs to be creative, demonstrate value and scalability, and result in beneficial system change.

The following conclusions can be drawn from the funding section of this environmental scan:

Conclusion One

HEALTH should consider initiating dialogue with potential funders, to identify their specific health care funding interests. These will change from time to time. Initiating this dialogue will also provide an opportunity to discuss with them the Rhode Island program and its accomplishments, uniqueness, and leadership position among public reporting programs.

Conclusion Two

Any initiative for which funding is sought should be well defined. This definition should include the scope of the initiative, the funding need, articulation of its uniqueness, and its potential relevance to the goals/purposes espoused by the funding sources.

Conclusion Three

The building of partnerships within the public reporting program itself is key to attracting foundation and federal government funding support.

Conclusion Four

Being flexible in the concept of the initiative is very important to allow the potential funder to establish the initiative's relevance to its available grant/contract program focus.

Conclusion Five

HEALTH should be proactive in its search for external funds. Each of the funding sources discussed herein is deluged with requests. Prior funder knowledge of the success

of the Rhode Island program and preliminary discussion with the funder of the concept the program is considering will build funder comfort level with the credibility, expertise, experience and commitment of the Rhode Island program in helping to achieve the goals of the funder (public or private).

APPENDIX A
LIST OF ORGANIZATIONS AND THEIR WEBSITES DISCUSSED IN THIS REPORT

Agency for Healthcare Research and Quality
http://www.ahcpr.gov

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov

The Foundation for Accountability
http://www.facct.org

Health Resources and Services Administration
http://www.hrsa.gov

The Joint Commission on Accreditation of Healthcare Organizations
http://www.jcaho.org

The Leapfrog Group
http://www.leapfroggroup.org

The National Committee for Quality Assurance
http://www.ncqa.org

The National Quality Forum
http://www.qualityforum.org

Pacific Business Group on Health
http://www.pbgh.org

Qualidigm
http://www.qualidigm.org

APPENDIX B

PAY FOR PERFORMANCE INITIATIVES

GROUPS WITH EXISTING PROGRAMS OR GROUPS WITH PROGRAMS UNDER DEVELOPMENT

EMPLOYERS	*BUSINESS COALITIONS*	*MCOs/PAYORS*	*PURCHASERS*
▪ General Motors ▪ CalPERS ▪ GE ▪ Verizon ▪ UPS	▪ Pittsburgh Regional Health Initiative ▪ Employer's Coalition on Health (IL) ▪ Central Florida Health Care Coalition ▪ Pacific Business Group on Health ▪ Massachusetts Health Quality Partners ▪ Tri-River Employers Health Coalition ▪ Leapfrog Group	▪ Pennsylvania Blue Cross Initiative ▪ Aetna's PCP Quality Incentives ▪ Anthem BCBS New Hampshire ▪ Harvard Pilgrim Awards for Excellence ▪ BCBS of Illinois Quality Payment ▪ Excellus Health Plan ▪ PacifiCare ▪ Tufts Health Plan	▪ Medicare Hospital Quality Incentive Demonstration Project ▪ Iowa Medicaid